STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. BUILDING 00 B. WING	09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN46168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaint IN00095341. Complaint IN00095341 : Substantiated, Federal/State deficiencies related to the allegations are cited at F281 and F333. Dates of survey: September 7 and 8, 2011 Facility number: 000121 Provider number: 155215 AIM number: 100290940 Survey team: Vanda Phelps, RN Census bed type: 12 SNF 135 SNF/NF 147 Total Census payor type: 17 Medicare 99 Medicaid 31 Other 147 Total Sample: 3 These deficiencies also reflect state	F0000	**Preparation and/or execution of this Plan of Correction in general, or any corrective action does not constitute an admission or agreement by Plainfield Health Care Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because of provisions of federal and/or state laws.** **Plainfield Health Care Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on September 15, 2011.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on September 15, 2011 by Bev Faulkner, RN			
F0281 SS=G	The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interviews, the facility failed to ensure LPN #2 followed the five rights of medication administration which resulted in giving the wrong type of insulin to a diabetic resident causing a hypoglycemic emergency. In addition, when the pharmacy contacted LPN #1 for clarification of the insulin order, evidence was lacking she contacted the attending physician, but instead, issued the clarification. This affected 1 of 3 residents in the sample of 3 reviewed for medication errors. (Resident IP) Findings include: Resident IP's closed medical record was reviewed on 9/7/11 at 2:40 p.m. The record indicated he was alert and oriented and had been admitted from a hospital. His diagnoses included, but were not limited to, insulin dependent diabetes, history of cardiac arrest, acute hypoxic respiratory failure secondary to congestive	F0281	**Corrective Action (F281): It is the policy of this facility that the medication administration guidelines are followed per physician orders. As of 8/18/2011, Resident #IP no longer resides at facility. At time of notification of medication error (9/8/11), the nursing administration began an audit reviewing residents with insulin administration orders and verifying appropriate insulin medications are in place. Please note, no negative findings occurred per this audit. On 9/9/2011, the Director of Nursing reviewed insulin medication error with the pharmacy. Pharmacy Director began internal investigation and stated reviewing internal procedures to ensure medication orders are filled per physician orders. The facility will continue to work with pharmacy on better communication.Per the 2567, four pharmacists were**	09/15/2011

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	heart failure and ventricular tachycardia and fibrillation. He arrived at the facility the evening of 8/17/11. Amongst his medication orders were orders for NPH/regular insulin to be given according to the results of his capillary blood glucose monitoring results: 1. "NPH insulin/regular, 40 units subcutaneously every evening with accucheck. Hold if blood sugar less than 200, resume if blood sugar greater than 200 " 2. "NPH insulin/regular, 65 units subcutaneously every morning with accucheck. Hold if blood sugar less than 200, resume if blood sugar greater than 200. " During interviews, 4 of 4 Registered Pharmacists (#1 on 9/11/11 at 4:36 p.m., #2 on 9/11/11 at 4:50 p.m., #3 on 9/11/11 at 8 p.m. and #4 on 9/12/11 at 8:28 a.m.) individually indicated an NPH/regular insulin order would need further clarification before it could be filled. They indicated this would be a combination of NPH and regular insulin and would need the ratio specified. Pharmacist #3 indicated a 65 unit dose of plain Humalog would be a very large dose. "I don't think I've ever seen such a large dose of Humalog."		**interviewed and two pharmacist's statements were noted saying the order of 65 units was a large dose and should be clarified with the physician. However, there is no documentation from the pharmacy that the physician was notified of the need for a clarification. Per a conversation on 9/9/2011 between the Director of Nursing and Pharmacy Director, the only documentation was a written note on order that stated clarification per Nurse. LPN #1 denies authorizing pharmacy to send Humalog in place of actual admission order of NPH insulin. Director of Nursing and/or designee will monitor residents receiving insulin administration. This will be done three times weekly. This monitoring tool will include, review of appropriate insulin administration, documentation, accuchecks, correct insulin on hand, and dates of insulin opened. These audits will be done until there are four weeks of zero negative findings then as needed thereafter. Any negative findings during these monitoring will be immediately corrected. As of 9/9/2011, LPN #2 no longer works for facility. On 9/12/2011, an insulin**	

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	The interview with Pharmacist #4 at the provider pharmacy on 9/12/11 at 8:28 a.m., indicated they had documentation they had contacted the facility for clarification. He indicated there was a notation on the record, "Per (LPN#1's name)-insulin orders are Humalog." This form was reviewed on 9/13/11 at 9 p.m., and matched Pharmacist #4 ' s information. Review of the shipping manifest, dated 8/17/11 at 11:41 p.m., indicated the pharmacy had shipped one 10 ml (milliliter) vial of "Humalog 100 units/ml" to the facility for Resident IP. It was not a combination of NPH and Humalog, but plain Humalog insulin. Interview of Physician #2 on 9/13/11 at 12:35 p.m., indicated he, too, thought the order needed to be clarified and changed to a combination product such as Humulin 70/30, etc. He indicated 65 units of plain Humalog would be a huge dose and could have been fatal depending on the size of the recipient, with a smaller person being at the greatest risk. Review of the 8/17/11 Record of Inquiry form indicated Resident IP's weight was at 309 pounds. His weight and the fact he ate a good breakfast helped explain why his blood sugar didn't crash earlier in the morning. Review of the Medication Administration Record (MAR) for Resident IP on 9/7/11		**administration in-service was provided to all licensed nurses by the Director of Nursing on following medication administration guidelines, verifying physician orders, difference between insulin types, and review of this finding. Any staff who fails to comply with the points of the in-service will be further disciplined as appropriate. At the Quality Assurance meeting held quarterly, the Director of Nursing or designee will review the monitoring of insulin administration and any negative patterns will be reviewed and addressed if necessary, an action plan will be written by staff appointed by the administrator and will monitor the plan weekly until resolution.**	

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	at 2:40 p.m., indicated 65 units of NPH insulin had been injected into his right arm at 7 a.m., on 8/18/11. (The accepted practice is that the medication could be administered anytime in a period of 1 hour before to 1 hour after the documented administration time.) The nursing notes indicated he was found cold and clammy at 11:20 a.m. on 8/18/11. Interview with the family on 9/7/11 at 6:28 p.m., indicated they arrived and found the resident "sprawled sideways across his bed, unconscious." The nursing notes indicated his blood sugar was at 61 then and 50 five minutes later. The physician was notified and ordered a tube of Instaglucin (a dose of 24 grams of carbohydrate gel designed to immediately impact low blood sugar). This was given and the blood sugar recheck was at 51. The EMTs arrived and transported the resident to the emergency room. The hospital emergency room documentation was reviewed on 9/8/11 at 1 p.m. This documentation indicated the EMTs had obtained a blood sugar reading of 30 while en route to the emergency room. They had given Resident IP two doses of dextrose-50 to counteract this low blood sugar. Interview with the Director of Nursing on 9/8/11 at 1:40 p.m., indicated their practice is to fax the physician's orders to			

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	their pharmacy provider who then fills the prescriptions and delivers them to the facility. During interview on 9/13/11 at 2 p.m., LPN #1 indicated she could not specifically remember the phone call from the pharmacy "because it happens a lot" and could not say what she'd checked before authorizing the Humalog order. She said, "I always check the orders in the chart." She indicated she had no memory of having called the attending physician about it. WebMD referenced Humalog insulin as a rapid-acting insulin, beginning action within 15-30 minutes and with peak action 30-90 minutes after the injection, with a duration of 3-5 hours. NPH insulin was classified as a intermediate-acting insulin taking effect in 1-2 hours and peaking at 2-5 hours, with a duration of 18-24 hours. Resident IP's hypoglycemic event was approximately four hours after receiving the injection, coinciding with the actions of plain Humalog insulin and the fact he had eaten a good breakfast. Based on the actions of Humalog insulin verses NPH insulin and the amounts of Humalog documented as received the night of 8/17/11 and disposed of after one			

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	dose was given, it was determined the morning nurse (LPN#2) failed to check the type of insulin she was administering with the type of medication the physician had ordered. The Administrator and Director of Nursing were informed of the above findings on 9/8/11 at 1:50 p.m. They indicated this issue had not been identified by their staff and offered no rebuttal. Page 171 of the Geriatric Medication Handbook , eighth edition, indicated under "Steps of Medication Administration" included the five administration rights: "accurate medication administration (i.e., right drug, right patient, right dose, and dosage form, right time)" This federal tag relates to complaint number IN00095341. 3.1-35(g)(1)			
F0333 SS=G	The facility must ensure that residents are free of any significant medication errors. Based on record review and interviews,	F0333	**Corrective Action (F333): It is the policy of this facility to**	09/15/2011

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	the facility failed to ensure 1 of 3 residents sampled for medication errors in the total sample of 3 was free of significant medication error in that he received insulin which was not ordered for him, resulting in a hypoglycemic emergency. (Resident IP) Findings include: The closed medical record of Resident IP was reviewed on 9/7/11 at 2:40 p.m. It indicated this resident was alert and oriented and had been admitted from a hospital. His diagnoses included, but were not limited to, insulin dependent diabetes, history of cardiac arrest, acute hypoxic respiratory failure secondary to congestive heart failure and ventricular tachycardia and fibrillation. Review of the 8/17/11 Record of Inquiry form indicated Resident IP's weight was at 309 pounds. He arrived at the facility the evening of 8/17/11. Review of the hospital discharge summary,dated 8/17/11, indicated the physician made a special note about Resident IP's insulin regime: "of note, holding all his insulin at this time. I am doing this because of his blood sugars have been running somewhat low on significantly lower doses of insulin that (sic) he was requiring prior to admission."		**ensure residents are free of significant medication errors, specifically insulin administration. As of 8/18/2011, Resident #IP no longer resides at facility. At time of notification of medication error (9/8/11), the nursing administration began an audit reviewing residents with insulin administration orders and verifying appropriate insulin medications are in place. Please note, no negative findings occurred per this audit. On 9/9/2011, the Director of Nursing reviewed insulin medication error with the pharmacy. Pharmacy Director began internal investigation and stated reviewing internal procedures to ensure medication orders are filled per physician orders. The facility will continue to work with pharmacy on better communication.Per the 2567, four pharmacists were interviewed and two pharmacist's statements were noted saying the order of 65 units was a large dose and should be clarified with the physician. However, there is no documentation from the pharmacy that the physician was notified of the need for a clarification. Per a conversation on 9/9/2011 between the Director of**	

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	The actual admission insulin orders were: 1. NPH insulin regular, 40 units subcutaneously every evening with accucheck. Hold if blood sugar less than 200, resume if blood sugar greater than 200 2. NPH insulin regular, 65 units subcutaneously every morning with accucheck. Hold if blood sugar less than 200, resume if blood sugar greater than 200. Review of the Medication Administration Record on 9/7/11 at 2:40 p.m., indicated Resident IP received his first dose of insulin at this facility at 7 a.m., on 8/18/11. His accucheck/capillary blood glucose reading had been 202. To be noted, it is acceptable practice for the medication to actually be given to the resident anytime between one hour prior and one hour after the documented time. Therefore resident IP's insulin was given between 6 a.m. and 8 a.m. The nurse (LPN #2) who administered the insulin remained unavailable for interview. The nursing notes indicated Resident IP was found cold and clammy at 11:20 a.m. on 8/18/11. Resident IP's family indicated during interview on 9/7/11 at 6:28 p.m., they found him unconscious and "sprawled sideways across his bed" when they arrived at 11:20 a.m. His blood		**Nursing and Pharmacy Director, the only documentation was a written note on order that stated clarification per Nurse. LPN #1 denies authorizing pharmacy to send Humalog in place of actual admission order of NPH insulin. Per 2567, a reference was made to resident discharge summary dated 8/17/2011. The resident was admitted to facility from hospital on 8/17/2011, however, the discharge summary was not sent from the hospital unit 8/18/2011, which is verified by the time stamp on the summary. Director of Nursing and/or designee will monitor residents receiving insulin administration. This will be done three times weekly. This monitoring tool will include, review of appropriate insulin administration, documentation, accuchecks, correct insulin on hand, and dates of insulin opened. These audits will be done until there are four weeks of zero negative findings then as needed thereafter. Any negative findings during these monitoring will be immediately corrected. As of 9/9/2011, LPN #2 no longer works for facility. On 9/12/2011, an insulin administration in-service was provided to all licensed nurses**	

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	sugar was at 61 then and 50 five minutes later. The physician was notified and ordered a tube of Instaglucin (a dose of 24 grams of carbohydrate gel designed to immediately impact low blood sugar). This was given and the blood sugar recheck was 51. The EMTs arrived and transported the resident to the emergency room. Review of the emergency room documentation for Resident IP on 8/18/11 indicated he arrived at 12:48 p.m. The EMT's reported an accucheck they did was at 30 and had given him an ampule of dextrose-50 which raised the blood sugar to over 100, but a recheck was at 65 so another ampule of dextrose-50 was given. His sugar then rose to 94. By the time he arrived in the emergency room, Resident IP was responding in one word sentences and was alert and oriented X 3. Review of the medication disposition sheet for Resident IP in his closed record indicated "9" Humalog insulin was destroyed upon his discharge from the facility on 8/24/11. Review of the shipping manifest form which recorded receipt from the pharmacy of medications for Resident IP on 8/17/11 at 11:41 p.m., indicated "10 cc" (cubic centimeters) of Humalog insulin, not NPH/regular insulin, had been delivered for this		**by the Director of Nursing on following medication administration guidelines, verifying physician orders, differences between insulin types, and review of this finding. Any staff who fails to comply with the points of the in-service will be further disciplined as appropriate. At the Quality Assurance meeting held quarterly, the Director of Nursing or designee will review the monitoring of insulin administration and any negative patterns will be reviewed and addressed if necessary, an action plan will be written by staff appointed by the administrator and will monitor the plan weekly until resolution.**	

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	resident. One (1) cc of the Humalog insulin had been removed. This was documented on both forms as plain Humalog, not a combination product. WebMD referenced Humalog insulin as a rapid-acting insulin, beginning action within 15-30 minutes and with peak action 30-90 minutes after the injection, with a duration of 3-5 hours. NPH insulin was classified as a intermediate-acting insulin taking effect in 1-2 hours and peaking at 2-5 hours, with a duration of 18-24 hours. Resident IP's hypoglycemic event was approximately four hours after receiving the injection, coinciding with the actions of Humalog insulin. Four Registered Pharmacists were interviewed separately about this scenario. #1 on 9/11/11 at 4:36 p.m., #2 on 9/11/11 at 4:50 p.m., #3 on 9/11/11 at 8 p.m., and #4 on 9/12/11 at 8:28 a.m. Four of 4 individually indicated an NPH/regular insulin order would need further clarification before it could be filled. They indicated this would be a combination of NPH and regular insulin and would need the ratio specified. Pharmacist #3 indicated a 65 unit dose of plain Humalog would be a very large dose. "I don't think I've ever seen such a large dose of Humalog."			

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	The interview with Pharmacist #4 at the provider pharmacy indicated their documentation showed they had contacted the facility for clarification. A time was not documented, but it would have been before the order left their premises the evening of 8/17/11. He indicated there was a notation on the record, "Per (LPN#1's name)-insulin orders are Humalog." This form was reviewed on 9/13/11 at 9 p.m., and matched Pharmacist #4's information. Review of the shipping manifest, dated 8/17/11 at 11:41 p.m., indicated the pharmacy had shipped one 10 ml (milliliter) vial of "Humalog 100 units/ml" to the facility for Resident IP. It was not a combination of NPH and Humalog, but plain Humalog insulin. Attempts to interview Resident IP's attending physician were unsuccessful, but a non-involved physician (MD #2) agreed to interview about this scenario on 9/13/11 at 12:35 p.m. He indicated he thought the order needed to be clarified and changed to a combination product such as Humulin 70/30, etc. He indicated 65 units of plain Humalog would be a huge dose and could have been fatal depending on the size of the recipient, with a smaller person being at the greatest risk. The resident's weight of 309 pounds			

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	and the fact he ate a good breakfast helped explain why his blood sugar didn't crash earlier in the morning. The Administrator and Director of Nursing were informed of the above findings on 9/8/11 at 1:50 p.m. They indicated this issue had not been identified by their staff and offered no rebuttal. This federal tag relates to complaint number IN00095341. 3.1-25(b) 3.1-48(c)(2)			